

US EPA RECORDS CENTER REGION 5



514651

931681

012583

## FIRST REPORT OF INJURY

NON-RESPONSIVE

SEND THIS REPORT IN TRIPLICATE TO:

EMPLOYERS MUTUAL LIABILITY INSURANCE  
COMPANY OF WISCONSIN

P. O. BOX 1357 • MINNEAPOLIS, MINNESOTA 55440 • PHONE (612) 927-2941

INSURER'S MINNESOTA WITHHOLDING TAX NUMBER 866379

WE WILL FILE A REPORT WITH  
THE MINNESOTA WORKMEN'S COMPENSATION COMMISSION WHEN NECESSARY.

Employee's Social Security Number

002. 16, 1970

Date of Claimed Injury

23

866641

Employer's Minnesota Withholding Tax Number

NON-RESPONSIVE

EMPLOYEE

- NON- Sex M ☒ F ☐ Occupation DAY WORKER
4. Marital status: Single ☒ Married ☐ Separated ☐ Divorced ☐
5. Type of employment: Full-time ☒ Part-time ☐ Seasonal ☐ Volunteer ☐ If other, specify \_\_\_\_\_
6. Type of work program, if applicable: Apprentice ☐ GI ☐ If other, specify \_\_\_\_\_
7. Average earnings per week \$ 118.40. Check if earnings are based on piece work. ☐
8. Straight-time worked: Hours per day 8 Number of days worked per week 5
9. Average over-time worked: Hours per day \_\_\_\_\_ Number of days worked per week \_\_\_\_\_
10. Straight time rate: \$ 2.96 per hour. Over-time rate: \$ \_\_\_\_\_ per hour.
11. If part-time worker, state total amount earned, total number of days worked and total number of weeks worked in the last 26 weeks. \$ \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ Number of hours normally worked by full-time employees per week \_\_\_\_\_
12. If furnished in addition to wages, state weekly value of: Board \$ \_\_\_\_\_; Lodging \$ \_\_\_\_\_; Other \$ \_\_\_\_\_
13. Did employee have other regular employment at time of injury? If yes, where? \_\_\_\_\_

EMPLOYER

14. Employer FEELY TAP & CHEMICAL CORP. PLANT # 2 Tel. No. 929-7351
15. Type of ownership: Individual ☐ Partnership ☐ Corporation ☒ If other, specify \_\_\_\_\_
16. Employer's address 7200 WALKER STREET  
City ST. LOUIS PARK State MINNESOTA Zip Code 55126
17. Name of employer representative or supervisor who first received knowledge of injury R. GRANN
18. Date when notice was received 10-23-70 Time of day injury occurred 9:45 A.M. \_\_\_\_\_ P.M.
19. Location where injury occurred LUMBER YARD

NATURE  
AND  
EXTENT  
OF INJURY  
OR  
DISEASE

20. Nature of claimed injury or disease RASH ON PALM OF RIGHT HAND
21. Did claimed injury or disease cause loss of time? Yes ☒ No ☐ If yes, last day worked? 10-22-70
22. Were full wages paid for last day worked? Yes ☒ No ☐
23. Has employee returned to work? Yes ☒ No ☐ If yes, when 10-27-70
24. If injury or disease resulted in death to employee complete the following: Date of death \_\_\_\_\_  
Name of dependent or next-of-kin \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_

MEDICAL  
AND  
HOSPITAL

25. Name of treating physician ST. LOUIS PARK MEDICAL CENTER Tel. No. 927-3123  
Address 5000 WEST 39TH STREET ST. LOUIS PARK, MINN.
26. Hospital \_\_\_\_\_ Address \_\_\_\_\_
27. Did employer authorize medical treatment? Yes ☒ No ☐

CAUSE  
OF  
INJURY

28. Describe how injury occurred HANDLING TRIMMED LUMBER
29. Machine, tool or appliance causing injury TRIMMED LUMBER
30. Did any employee physical handicap contribute to cause of injury? Yes ☐ No ☒ If yes, how? \_\_\_\_\_
31. What action has been taken to prevent recurrence? \_\_\_\_\_

Dated NOVEMBER 16 19 70  
(OBSERVE INSTRUCTIONS ON REVERSE SIDE.)WC 102 Dec 1969 replaces CI which shall not be used  
11/16/70Signed by [Signature] 9509122  
Official Title PLANT MANAGER  
Phone No. 929-7351